THE MISSOURI SENATE INTERIM COMMITTEE ON MEDICAID TRANSFORMATION AND REFORM

MINORITY REPORT

December 3, 2013

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The Honorable Tom Dempsey, President Pro Tempore
State Capitol, Room 326, Jefferson City, Missouri 65101

Dear Mr. President:

The Senate Interim Committee on Medicaid Transformation and Reform, acting pursuant to Senate Rule 31 of the Missouri Senate, has met, taken testimony, deliberated, and concluded its study on the various issues facing Medicaid in Missouri as it relates to reforming Medicaid by improving system efficiency, financial stability and delivery of care. The minority members of the committee now present to the General Assembly a minority report of information and proposed recommendations of actions to address this issue.

Senator Joseph Keaveny

Senator Paul LeVota

Senator Jamilah Nasheed

EXECUTIVE SUMMARY

The Senate Interim Committee on Medicaid Transformation and Reform has failed to fulfill its stated purpose, which, according to the committee's webpage was to improve "system efficiency, financial stability and delivery of care." The committee's report is not based on the actual testimony and information presented to the committee as it ignores those who testified regarding Medicaid expansion in Missouri.

When minority members requested the committee report contain information regarding Medicaid expansion they were told such a subject was "not under the purview of the committee's responsibility" despite the fact that 52.4% of the committee testimony related to Medicaid expansion. After rejecting the topic of Medicaid expansion, the committee added Tort Reform to the report's Recommendations section despite a complete lack of committee discussion and witness testimony on the matter.

Healthcare service delivery is far too important in terms of lives, jobs, and the economy for the minority members of this committee to be complicit in the majority's lack of seriousness in crafting meaningful healthcare policy. This Minority Report seeks to correct the committee's oversight by providing information based on the actual testimony presented to the committee. This report recommends that:

- Medicaid eligibility be expanded to those citizens with incomes up to 138% of Federal Poverty Level;
- A hybrid approach based on the "premium assistance" model be adopted if traditional Medicaid expansion is not politically feasible;
- Certain recommendations from the Majority Report be enacted along with Medicaid expansion, including: extending current Managed Care programs; transitioning populations currently in the fee-for-service programs into regionally-based Accountable Care Organizations; and reforming hospital payment structures; and
- Certain other recommendations from the Majority Report be enacted regardless of whether Medicaid is expanded, including: coordinating care for dual eligible individuals; better management of "super utilizers"; decreasing emergency room over-utilization; strengthening Missouri's MO HealthNet False Claims Act; increasing the asset limit; and adding preventive dental services for adults and the disabled.

INTRODUCTION

At the conclusion of the First Regular Session of the 97th General Assembly, President Pro Tempore Tom Dempsey, pursuant to powers afforded to him under Senate Rule 31, established the Senate Interim Committee on Medicaid Transformation and Reform. The interim committee's webpage states that "The committee was established with the goal of reforming Medicaid by improving system efficiency, financial stability and delivery of care." The committee was charged with issuing a report and making recommendations to the general assembly for legislative action no later than December 15, 2013.

It has now become apparent that the Senate Interim Committee on Medicaid Transformation and Reform has failed to fulfill its stated purpose.

The usual and proper course of action for Senate interim committees is as follows:

1. Senate leadership identifies an often difficult public policy issue and tasks an interim committee with investigating said issue;
2. The committee takes public and expert testimony regarding said issue;
3. The committee considers all of the relevant information gleaned from said testimony; and
4. After careful deliberation, the committee issues a well-reasoned report with recommendations for legislative action based on the testimony and information presented to the committee.

While the Senate Interim Committee on Medicaid Transformation and Reform did undeniably follow those first two steps, the committee has utterly failed to follow the latter two steps. The committee's report is not based on the actual testimony and information presented to the committee. Specifically, the report all but ignores the experts and citizens who testified both for (93.9%) and against (6.1%) the expansion of Medicaid in Missouri. The report not only fails to discuss Medicaid expansion in its "Recommendations" section, it also under-reports the numerous arguments presented to the committee in favor of expansion. Nowhere in the report is there mention of the costs (in terms of dollars, jobs, or lives) of failing to expand Medicaid despite the numerous witnesses who testified regarding such. It should also be noted that the two individuals testifying in opposition to Medicaid expansion have also been disenfranchised by the committee's incomplete and inaccurate report.

Observing this omission in the draft committee report, the minority members of the committee asked for the inclusion of the following statement to the report:

> "The majority of the testimony before this committee stated that in order to save Missouri money and increase access to healthcare, the state should expand Medicaid to 138% of the federal poverty level and accept the federal moneys associated with such."

Note that this suggested addition to the report is not a recommendation by the committee to expand Medicaid, but purely a statement of historical fact. And those facts[1] are clear:

Of the 63 people who appeared before the committee:

- Number of people testifying regarding expansion: **33**
- Percentage of people testifying regarding expansion: **52.4%**
- Percentage of those in favor of expansion: **93.9%**
- Percentage of those against expansion: **6.1%**
- Percentage of those testifying who were told that their Medicaid expansion testimony was beyond the purview or the auspices of the committee: **0%**

In response to the minority members' request to amend the report, the committee chair replied that "Medicaid expansion was not under the purview or the auspices of this committee's responsibility." In other words, despite the fact that 33 individuals (52.4% of the total witnesses) testified regarding Medicaid expansion, their testimony was apparently wholly irrelevant – a fact they were not apprised of before or during their testimony.

Another proposed addition to the report by the minority members (which simply stated that the General Assembly should consider waiver options for expansion) was also rejected by the committee using the same "beyond the purview" argument. This rejection squarely contradicts one of Senator Dempsey's direct charges, which tasked the committee with exploring "how coverage for MO HealthNet participants can

[1] See Appendix A for a complete list of those of testified in favor, against, or expressed no opinion on Medicaid expansion. This tally does not include the 1700+ signatures on the petition favoring Medicaid expansion given to the committee by Jeanette Mott Oxford, Executive Director of the Missouri Association of Social Welfare.

resemble that of commercially available health plans while complying with federal Medicaid requirements." Senator Dempsey's goal can only be achieved via a federal waiver.

To this end, the committee never bothered to discuss the plan being crafted in the Missouri House by State Representative Jay Barnes (Republican – Jefferson City). Rep. Barnes' plan is similar to the Arkansas and Indiana "Premium Assistance" models, as it envisions adding adults with incomes below the poverty level to the traditional Medicaid system while also drawing down federal dollars to assist those earning between 100% and 138% percent of the poverty level in buying private insurance. If Representative Barnes' plan were to become law, the state would be required to apply for a Medicaid 1115 waiver from the federal government. In doing so, Representative Barnes would accomplish Senator Dempsey's request to develop a system for "coverage for Medicaid participants resembling that of commercially available health plans while complying with federal Medicaid requirements."

In fact, any potential market-based Missouri-specific expansion proposal would require the state to obtain a Medicaid 1115 waiver. Yet the committee rejected the Minority's request to append a statement urging the General Assembly to consider waiver options for expansion as "beyond the purview," despite the language of the official committee charge from the President Pro Tempore.

Immediately after the committee voted down the Minority members' "beyond the purview" additions to the report, the committee did approve an addition to the report to include Tort Reform in the committee's recommendation section.

Of the 63 people who appeared before the committee:

- Number of people testifying regarding Tort Reform: **0**
- Percentage of people testifying regarding Tort Reform: **N/A**
- Percentage of those in favor of Tort Reform: **N/A**
- Percentage of those against Tort Reform: **N/A**
- Percentage of those testifying who were told that their Tort Reform testimony was within purview or the auspices of the committee: **N/A**

Unlike Medicaid expansion, the committee never discussed the concept of Tort Reform. However, the committee had no objection to adding Tort Reform to the report's recommendation section.

After the committee publically declared Tort Reform within the purview and Medicaid expansion and waiver requests outside the purview, it became all too clear to the minority members that the Senate Interim Committee on Medicaid Transformation and Reform was created purely to reach a predetermined outcome. Why hold meetings from July to November when the report could have essentially been written in June? Why take hours of testimony on a serious public policy subject just to ignore the overwhelming majority of that testimony? Why waste the time of 33 Missourians, both for and against Medicaid expansion, when their testimony was meaningless?

In retrospect, this turn of events should have been foreseen, as this Senate majority has developed a disturbing pattern with regard to Healthcare interim committees.

In 2011, President Pro Tempore Robert Mayer established The Senate Interim Committee on Health Insurance Exchanges in order to "explore Missouri's options on the establishment of a health insurance exchange." Like the Medicaid Transformation interim committee, the Health Insurance Exchange interim committee also met and took testimony, an overwhelming majority of which supported the establishment of the state-run health insurance exchange in Missouri. To date, the Secretary of the Senate has not yet received that Insurance Exchange interim committee report.

Viewed in the context of the 2011 Health Insurance Exchange committee, perhaps the Medicaid Transformation committee could be viewed as somewhat of an accomplishment. It does appear likely that this committee will actually write and submit a report, not one based on the overwhelming facts presented to it, but a report nonetheless.

Regrettably, healthcare service delivery is far too important in terms of lives, jobs, and the overall economic well-being of the state for the undersigned members of this committee to be complicit in the majority's lack of seriousness in crafting meaningful healthcare policy. We will no longer accept the majority's slouch toward a solution.

It is regrettable that this Minority Report had to be composed. Regardless, the undersigned Senators believe that it is both necessary and prudent to provide information to the public based on the actual testimony presented to the committee. To that end, this report will now discuss the healthcare policy recommendations presented to the committee that did not fit into the majority's predetermined agenda.

POLICY RECOMMENDATIONS

While there are several other troubling aspects concerning the development of the Majority Report, this Minority Report will now turn to the important task of making policy suggestions based on evidence from the testimony heard by the committee. Therefore, the signers of this Minority Report urge the General Assembly to consider the following recommendations for action:

1. **Expand Medicaid. Medicaid eligibility should be expanded to those Missouri citizens with incomes up to 138% of Federal Poverty Level without delay.**

This recommendation is based on the overwhelming testimony presented to the committee, which robustly articulated the moral, economic, budgetary, and societal benefits of Medicaid expansion.

First and foremost, the undersigned Senators believe that denying any human being healthcare is simply intolerable in a country as wealthy as the United States. While this moral principle is not a quantifiable justification for Medicaid expansion, it should not be ignored as a reason for supporting expansion. Moral beliefs aside, there is quantifiable evidence that Medicaid expansion will, indeed, save lives.

Professor Sidney Watson, who appeared in front of the committee on September 11, noted in her testimony: "The most significant Medicaid Transformation and Reform Initiative is expansion of coverage for adults with incomes up to 138% of Federal Poverty Level." She further stated: "A large body of research shows that Medicaid coverage lowers financial barriers to access to health services and increases likelihood of having a usual source of care, which translates into increased use of preventive, primary, and other care, and improvement in some measures of health care. Medicaid coverage actually saves lives. A ten year study that compared three states that expanded Medicaid coverage for low income adults with neighboring states that did not concluded that for every 176 additional adults covered by Medicaid it saves one

life per year over ten years. In Missouri that means if we expanded Medicaid to cover an additional 260,000 adults we would save 14,770 lives over ten years."[2]

Not only will Medicaid expansion save lives, but health coverage serves an essential purpose other than ensuring health and preserving life: it protects people from financial catastrophe.

More than 62% of all bankruptcies in the United States are attributed to the cost of medical care.[3] The notion that a citizen of the richest country in the world can go bankrupt because they develop cancer is inexcusable. Studies have demonstrated that Medicaid serves a dual purpose, as Medicaid virtually eliminates catastrophic medical costs.[4]

The committee also heard numerous persuasive economic arguments in support of Medicaid expansion.

The Business Health Coalition stated in its testimony that "Medicaid expansion is more than a moral imperative; it will have a substantial impact on Missouri's economy… The cost of care for any one population or program impacts the cost of care for everyone. Ultimately that price is paid by all Missourians, directly and indirectly. Our goal should be to drastically cut the rate of growth for all."

One of the key findings from a report presented to the committee (prepared for the Missouri Hospital Association[5]) states that the decision to expand Medicaid carries the potential to substantially reduce the "hidden health care tax" burden (more colloquially known as the "cost-shift") for privately insured Missourians and their employers. Cost-shifting occurs when some payers underpay health care providers relative to the costs of providing care. These costs are then passed on to private

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[2] The full text of Sidney Watson's testimony can be found here: http://slu.edu/Documents/law/Centers/Health%20Law/Medicaid/WatsonSenateInterimMedicaidTestimony9-11-2013.pdf

[3] American Journal of Medicine: Medical Bankruptcy in the United States, 2007: Results of a National Study. http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934309004045.pdf

[4] Oregon Health Study Findings: http://oregonhealthstudy.org/for-participants/findings/

[5] The Economic Impacts of Medicaid Expansion On Missouri. Prepared by the University of Missouri School of Medicine for The Missouri Hospital Association and Missouri Foundation for Health. http://web.mhanet.com/uploads/media/MU_Medicaid_Expansion_Economic_Report.pdf

payers in the form of higher premiums. Without Medicaid expansion, the average private insurance premium for a family of four in Missouri is projected to increase significantly. With Medicaid expansion, privately insured individuals and families could potentially save nearly $1 billion[6] due to reductions in premiums.

This "cost-shift" discussion hinges on the fact that not having insurance doesn't actually mean not having any access to healthcare. The current healthcare system provides care for the uninsured population by providing life-saving treatments when a person needs it, notwithstanding their ability to pay. This requirement became law in 1986 when Congress passed the Emergency Medical Treatment & Labor Act. While treatment in the Emergency Room may bankrupt a person, such treatment generally accomplishes enough to keep that person alive. When the uninsured seek hospital care, people who are insured pay for part of this care through health insurance premiums. At a minimum, the committee should have discussed the most logical manner in which to provide the care that is *already being provided* to the uninsured.

According to the Missouri Hospital Association report, expanding Medicaid would result in the creation of over 24,000 new jobs in Missouri. The report calculates the total effects (direct, indirect and induced) of expanding Medicaid in Missouri to be an additional $9.6 billion of value-added output to the state. The severe economic consequences of inaction cannot be over-emphasized.

Official projections[7] from the office of Budget and Planning estimate that the state would realize significant savings (over half a billion dollars over the subsequent seven fiscal years) to the General Revenue fund if Medicaid is expanded in Missouri, leaving more money for other needed government services such as education, law enforcement, and transportation. This General Revenue savings estimate corresponds to the survey released by the Kaiser Commission, which found that states not expanding Medicaid are expecting a larger increase in their state budget portions dedicated to Medicaid. State spending growth will be lower for the 25 states that are moving forward with Medicaid expansion (4.4 percent) compared to the remaining states (6.1 percent).[8]

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[6] Ibid., Page 7.

[7] See Appendix B for the Office of Budget and Planning's full Cost estimates

[8] The Kaiser Commission on Medicaid and the Uninsured: Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014. (Page 21.) http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time4.pdf

2. **If traditional Medicaid expansion is not politically feasible, adopt a hybrid approach based on the "premium assistance" model being proposed by Representative Jay Barnes (R-Jefferson City).**

While the undersigned Senators strongly believe that Medicaid eligibility should be expanded to those Missouri citizens with incomes up to 138% of Federal Poverty Level as envisioned by the Affordable Care Act, they are willing to accept any reasonable compromise in this area including a hybrid expansion approach more in line with the majority's overall governing philosophy. While not preferable to traditional Medicaid expansion, a market-based expansion is better than no expansion at all. Further, a market-based expansion may possess certain benefits, as some Medicaid recipients would be transformed into active health care consumers empowered to choose their own health insurance plans, introducing "cost-consciousness" into their decisions.

The "premium assistance" expansion model is a market-based approach to fund health care for the poor in place of conventional Medicaid expansion. The adoption of such a model would necessitate Missouri obtaining a Medicaid 1115 waiver. Such waivers allow states to use federal Medicaid funding to buy private insurance for low-income people from the health insurance exchanges created under the Affordable Care Act.

State Representative Jay Barnes (Republican – Jefferson City) is proposing a plan that is similar to the Arkansas and Indiana "Premium Assistance" models. Barnes' plan would add approximately 225,106 adults (with incomes below the poverty level) to the traditional Medicaid system while also drawing down federal dollars to assist an additional 82,433 Missourians (making between 100% and 138% percent of the poverty level) in purchasing private insurance.

According to Representative Barnes' self-described "conservative" scoring methodology, his proposal would result in savings to General Revenue of over $779 Million between fiscal years 2014 and 2021.

While the undersigned Senators possess reservations regarding specific elements of Rep. Barnes' proposal (such as the alteration of the term "affordable" in Section 208.640 and the corresponding reduction to the CHIP program) the overall plan is worthy of serious consideration. At a minimum, the General Assembly should use

Mr. Barnes' proposal as a blueprint for market-based expansion if traditional Medicaid expansion is not politically feasible.

3. **The General Assembly needs to outgrow partisan politics and recognize that regardless of how one feels about President Obama and his healthcare bill, Medicaid expansion will save the state money.**

While this recommendation is not a true policy proposal (and obviously can't be legislated) it will nevertheless be necessary if the General Assembly is going to adopt any expansion model. To date, there have been four general varieties of arguments against expanding Medicaid:

1) Medicaid needs to be reformed first;
2) The state already spends too much on healthcare for the poor and cannot afford to further expand Medicaid;
3) Medicaid is not a worthwhile program and therefore should not be expanded; and
4) The federal government cannot be trusted to fulfill the enhanced match rates contained in the Affordable Care Act and therefore the state will be left footing the bill.

The Majority Report states the first argument against expansion directly, asserting that before the state can "consider" expanding eligibility and increasing the number of participants, transformation of the entire Medicaid program must occur. To this end, the report contains several recommendations designed to reform the Medicaid program in Missouri. Now that the General Assembly is in possession of the required programmatic reforms, when is it acceptable to consider expansion? If a policymaker truly believed in the "reform then expand" position, that person would include (or at least consider including) expansion in the legislation that houses the reforms in order to accomplish that agenda. Also, the federal government is much more likely to approve a waiver for "reform" when it's paired with something they want – Medicaid expansion. Not including, or even considering, Medicaid expansion along with reform legislation exposes the evasive nature of those asserting this argument.

The second argument against expansion, that the state already spends too much on healthcare for the poor and cannot afford to further expand Medicaid, also lacks merit.

The Majority Report touches on this argument by reporting that the Medicaid appropriations in the FY 2014 budget are close to $9 billion, which is somewhat misleading. The state's General Revenue used to fund Medicaid is approximately $1.8 Billion. (Approximately $4.7 Billion of that $9 Billion is federal "flow-through" money over which the legislature has no control; the remaining $2.4 Billion comes from other sources, like provider taxes, etc.)

Put in proper context, it becomes apparent that the state of Missouri does not spend "too much" on its Medicaid program. [9]

- Missouri spends approximately 21% of its total General Revenue funds on the Medicaid program;
- The national average for all US states is 32.5% of General funds spent on Medicaid;
- Missouri is the ninth lowest state in the nation when comparing the percent of General Revenue funds spent on Medicaid.

The other portion of this budgetary argument, that the state cannot afford to further expand Medicaid, is also a fallacy. There are multiple sources of information (already presented in this report) that clearly contradict this assertion and demonstrate that the state General Revenue fund will save money under Medicaid expansion.

The Affordable Care Act provides full federal financing for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90 percent by 2020. Increases in state Medicaid spending will occur in all states, even those not expanding Medicaid, due to significant outreach efforts and what is being referred to as the "woodwork" effect.

There is evidence that this woodwork effect is already happening. Millions currently eligible but not yet enrolled people are expected to sign up as a result of the implementation of the Affordable Care Act. The first enrollment report released on November 13, 2013 demonstrates that this woodwork phenomenon is real, even in the Republican-led states that have fought the healthcare law and refused to expand their Medicaid programs. In the first month of open enrollment, about 91,000 people in the non-expansion states who would have qualified for Medicaid before but had

[9] The National Association of State Budget Officers. 2012. http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf

not signed up, came to the federal online marketplace and were deemed eligible for the program.[10]

In other words, Medicaid enrollment is going to increase in Missouri whether the state expands its Medicaid eligibility or not. States that do not expand will not receive the enhanced federal match rate for new enrollees and will not be able to transition a portion of their current Medicaid populations to the "newly eligible" group (and thus will not receive the financial benefits of the higher federal match for certain current enrollees.)

Medicaid expansion will generate extensive economic activity in the state by bringing in new revenue, creating new jobs, and expanding income in the healthcare sector due to the "multiplier effect." This multiplier effect will significantly increase economic activity for states that choose to expand Medicaid in relation to states that do not, as medical technology firms and healthcare providers will have economic incentives to invest and create jobs in expansion states over non-expansion states. Unlike the non-expansion states, expansion states will have advantages in improving their overall health care infrastructure, an important economic development aspect of expansion that is difficult to accurately quantify but is significant nonetheless. If the goal is to save state resources on Medicaid then the answer (though perhaps somewhat counterintuitive) is simple and undisputed: expand Medicaid.

The third argument, that Medicaid is not a worthwhile program and therefore should not be expanded, is also factually challenged.

During the July 9, 2013 meeting of the committee, Senator Schaaf (Republican - St. Joseph) referred to a flawed study from Oregon showing Medicaid generated no improvement in physical health outcomes. [11] Other comments from the Senator

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[10] http://capsules.kaiserhealthnews.org/index.php/2013/11/about-91000-enroll-in-medicaid-as-result-of-aca-woodwork-effect/

[11] There are multiple deficiencies in the study's methodology: the study wasn't blinded; the study authors only measured the baseline health status of the uninsured group, not the Medicaid group; the study contains no actual analysis of how a specific Medicaid patient progressed from the beginning of the study to the end; only 60 percent of those eligible to enroll in the Medicaid program did so, again introducing bias into the studied Medicaid population, as the subpopulation that actually signs up for benefits is more likely to need treatment (be sicker) than the subpopulation that does not sign up. Most of these methodological critiques were culled from: http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicaid-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/"

implied that persons enrolled in the Medicaid program were no better off than persons who lacked insurance entirely.

Contrary to the subtext of the Senator's comments, this lack of statistically significant positive health outcomes for Medicaid enrollees is not limited to the Medicaid program. A review of health care research reveals that the vast majority of studies examining the extent to which *any* health insurance improves health outcomes cannot determine a causal effect.[12] Yet no Senator on the committee suggested that a person with health insurance was no better off than a person who lacked health coverage entirely.

Further, Senator Schaaf's assertion fails to contemplate that health insurance coverage protects people from financial ruin and that enrollment in Medicaid virtually eliminates catastrophic medical costs, protecting our citizens from existing in a world where a single tragic health event automatically results in bankruptcy.

The fourth argument against Medicaid expansion is that the federal government will fail to fulfill its promise of enhanced federal match rates at some point in the future, leaving the state to foot the bill for expansion. This concern could easily be addressed by including a "severability clause" in the expansion legislation, allowing the state to reduce eligibility if the enhanced Federal match rates are reduced or eliminated.

In fact, 21 states have legislation (whether pending or not) that allows the state to discontinue expansion if the federal matching rate is reduced or if it falls below a certain threshold.[13]

4. Enact the following Recommendations from the Majority Report along with Medicaid expansion:

Despite the minority members' profound disappointment with the deficiencies of the Majority Report as a whole there are recommendations contained therein that were actually based on the information presented to the committee and to which the undersigned members would generally approve if coupled with some form of

[12] Said review was conducted for The Economic Research Initiative on the Uninsured (ERIU) at the University of Michigan by University of Chicago health economists Helen Levy, Ph.D., and David Meltzer, M.D., Ph.D. See: http://www.rwjf-eriu.org/pdf/research-highlight-mar.pdf

[13] https://www.statereforum.org/tracking-medicaid-expansion-decisions

expansion. It is regrettable that these areas of agreement could not have served as a basis to construct a truly bipartisan report.

Nevertheless, the minority members of the committee would largely support the following recommendations contained in the majority report if accompanied with some form of Medicaid expansion in order to create a more efficient and effective Medicaid system in Missouri:

- The Majority Report recommends that the current MO HealthNet Managed Care program should be extended statewide for certain or all populations currently in managed care, which would primarily include low-income custodial parents, pregnant women, and children. The minority members of the committee would support an extension of the Managed Care program to those populations (or perhaps to all populations) if such a policy alteration would advance the Medicaid expansion agenda.
- Transition populations (currently in the fee-for-service programs) to regionally-based Accountable Care Organizations. Based on the preponderance of the committee testimony, such a transition could lead to increased efficiency and delivery of care within the system.
- Hospital payment reforms should be explored, as MO HealthNet currently pays hospitals based on a complicated and outdated reimbursement methodology. A new payment structure should be developed in order to promote consistency among payers, quality, and value in hospital inpatient and outpatient settings. However, it should also be noted that Medicaid expansion is vital to continued hospital health, as the Affordable Care Act was crafted under the assumption that all states would expand Medicaid. Because of this assumption, the law contains cuts to other federal healthcare spending (such as Disproportionate Share Hospital funding) that were designed to be offset by increases in Medicaid coverage. While hospital payment reform is vital, Medicaid expansion is even more essential for hospital health in Missouri.

5. Enact the following Recommendations from the Majority Report regardless of whether Medicaid is Expanded:

The Minority Members of the committee would generally support the following recommendations contained in the majority report even if not accompanied with Medicaid expansion as these recommendations are based on the preponderance of the information presented to the committee and would enhance the state's healthcare service delivery:

- The DSS should develop options for coordinating care for dual eligible individuals (persons who meet eligibility requirements for both Medicare and Medicaid) in order to integrate Medicaid and Medicare services and provide a more effective and efficient method of healthcare service delivery.
- Technology should be utilized in order to further enhance both telehealth and transparency. While amorphous in nature, this recommendation is reasonable and congruent with committee testimony.
- Reforms should be implemented to better manage "super utilizers" and decrease emergency room over utilization. This goal could be partially achieved by extending the Managed Care program and transitioning populations to regionally-based Accountable Care Organizations as discussed above.
- Strengthen Missouri's MO HealthNet False Claims Act.
- Adopt Incentives for Participants to seek preventive services, encourage healthy behavior and to participate in his or her health care.
- Encourage health savings accounts that can be used for deductibles and copays.
- Increase the asset limit to allow for health care items or services.
- Add preventive dental services for adults and disabled to reduce ER visits.
- Reinvest future transformation savings into technology and provider payments.

Appendix

WITNESSES FOR MEDICAID EXPANSION		
For	**Against**	**No Mention**
Barbara Davis- League of Women Voters	Charles Willey, MD	Mary Schantz-MO Alliance for Home Care
Joel Ferber, Legal Services of Eastern Missouri	Jeanie Gault (Argued that before Med Exp, look at exp. for the aged, blind and disabled first- a social justice question)	Lauren Tanner-Ranken Jordan Pediatric Specialty Hospital
Anita Parran- AARP		Sergeant Mike Krohn-Boone County Sheriff
Todd Richardson-Missouri Assn for Community Action		Richard MCCullough- Missouri State Chiro. Assn
Missouri Developmental Disabilities council		Wayne Lee-Advocate for disabled
John Orear-NAMI and parent		Dr. Lee Parks- Crider Center
Erin Brower-Partnership for Children		Shelly Keller- self
Dr. Chuck Hollister -Missouri Psychological Assn		Mike Keller- Mo council for the Blind
Andrea Routh-MO Health Advocacy Alliance		Dr. Jeffery Kerr
Sara Guardilo-Student		Missouri Dental Association
Dawn Martin-Participant		Steve Halper-Healthcare Fraud Control Unit
Joe Hardy-Missouri Rural Crisis Center		Joan Gummels-AG
Wendy Chambers-Foster and Adoptive Parent		John Knopp-AG
April Neiswinder-self		Pam Victor-Aetna
Debbie Minton-self		Bob Adkins-Aetna
Jackie Lukitish- NAMI St Louis		Howard Weiss-AHIP
Michelle Scott-Huffman- Missouri Faith Voices		Bob Reed-Pageminder
Alaina Macia- Medical Transport Management		Well Point/Blue Cross Blue Shield-Christian Jensrud
Mo Coalition Community Mental Health Centers		Home State Health Plan
Mo Academy of Family Physicians		Dennis G. Smith-Mckenna, Long and Aldridge LLP
Sidney Watson-Professor- St. Louis University School of Law		Christie Herrera-Foundation for Government Accountability
Margarida Jorge-Healthcare for America Now		Ed Weisbart-Vice President-Missouri Consumer Council
Business Health Coalition		Brent Gilstrap- MO Mental Health Counselors Assn
Timothy McBride		Sara Gentry-MS Society
Craig Henning-Exec Director- Disability Resource Assn		BJC
Jeaneter Mott Oxford-Mo Assn Social Welfare +1700		MHA
Dr. Mark Bradford		Dr. Larry Lewis
James King-Adapt Missouri		Dr. John Marshall
Mercy Health		Jason White
Dr. Heidi Miller		Cerner
Steve Goldberg- Wellcare Health Plans		

Medicaid Expansion-Draft
Impact on New Eligibles

		FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	
A.	**Number of Newly Eligible Medicaid Participants**									
1.	Parents	115,685	115,685	115,685	122,626	129,567	129,567	129,567	129,567	Take up: 70% 2014-16, 75%-2017, 80%-2018-21
2.	Childless Adults	124,032	132,572	141,112	149,653	158,193	158,193	158,193	158,193	60%-2014, 65%-2015, 70%-2016, 75%-2017, 80%
3.	Medically Frail	19,782	19,782	19,782	19,782	19,782	19,782	19,782	19,782	95% each year
4.	Total	259,499	268,039	276,579	292,061	307,542	307,542	307,542	**307,542**	
B.	**Cost-For Newly Eligible Participants**									
1.	Parents	($295,228,120)	($593,276,466)	($602,786,700)	($635,562,228)	($694,049,896)	($740,241,898)	($768,460,180)	($799,328,353)	PMPM: $435.50 / $371.97 crowd out trended
2.	Childless Adults	($421,124,008)	($876,409,389)	($951,682,642)	($1,035,653,215)	($1,131,694,800)	($1,207,414,140)	($1,253,533,345)	($1,303,932,763)	PMPM: $582.55 / $486.61 crowd out trended
3.	Medically Frail	($191,135,894)	($388,100,804)	($400,843,961)	($414,939,280)	($430,616,399)	($447,971,948)	($466,074,646)	($485,298,482)	PMPM: $1,635 / $1,540 crowd out trended
4.	Total	($907,488,022)	($1,857,786,660)	($1,955,313,303)	($2,086,154,723)	($2,256,361,094)	($2,395,627,986)	($2,488,068,171)	($2,588,559,598)	
5.	State Share-GR	$0	$0	$0	($30,112,261)	($69,303,438)	($86,590,613)	($117,617,393)	($143,257,483)	
6.	State Share-Other	$0	$0	$0	($23,944,742)	($55,266,828)	($69,351,136)	($94,577,215)	($115,598,477)	
7.	Federal Share	($907,488,022)	($1,857,786,660)	($1,955,313,303)	($2,032,097,720)	($2,131,790,829)	($2,239,686,237)	($2,275,873,562)	($2,329,703,638)	
C.	**Savings-State Share Change in Existing Programs**									
1.	Pregnant Women	$14,031,232	$42,262,986	$57,649,242	$56,051,495	$53,549,081	$54,087,840	$52,758,603	$52,246,279	Coverage for 20,892 will be at enhanced rate
2.	Ticket to Work	$521,989	$1,357,171	$1,705,442	$1,653,183	$1,572,910	$1,586,251	$1,541,873	$1,522,533	Coverage for 225 will be at the enhanced rate
3.	Breast/Cervical Cancer	$1,363,670	$4,915,851	$8,223,776	$8,741,350	$8,310,441	$8,515,064	$8,276,841	$8,173,027	Coverage for 1,093 will be at enhanced rate
4.	Spenddown	$16,230,288	$33,142,247	$34,534,221	$33,577,107	$32,078,060	$32,400,799	$31,604,532	$31,297,628	Coverage for 3,118 will be at enhanced rate
5.	Women's Health Services	$522,249	$1,066,431	$1,111,222	$1,157,893	$1,206,524	$1,257,198	$1,310,001	$1,365,021	Coverage for 63,107 will be at enhanced rate
6.	Blind Pension	$627,067	$1,280,470	$1,334,250	$1,354,816	$1,368,854	$1,411,250	$1,438,741	$1,475,088	121 will get Medicaid coverage
7.	Corrections	$1,559,556	$3,119,112	$3,119,112	$3,119,112	$3,119,112	$3,119,112	$3,119,112	$3,119,112	150 inpatient hospital days per month
8.	DMH	$11,299,836	$22,599,671	$22,599,671	$22,599,671	$22,599,671	$22,599,671	$22,599,671	$22,599,671	33,829 will get Medicaid coverage
9.	Total	$46,155,884	$109,743,939	$130,276,936	$128,254,627	$123,804,653	$124,977,185	$122,649,373	$121,798,360	
10.	GR Share	$31,046,711	$71,355,159	$82,283,976	$81,243,754	$78,914,722	$79,579,907	$78,383,904	$77,975,810	
D.	**Revenue Increases -- GR**									
1.	Increased Ind Income Tax	$9,872,846	$30,537,382	$32,412,653	$33,523,622	$33,222,612	$33,523,852	$34,217,870	$34,810,951	Salary portion only at 4.5%. No multiplier.
2.	Increased Sales Tax	$1,914,734	$4,069,823	$4,309,206	$4,254,108	$4,249,218	$4,375,990	$4,387,800	$4,593,866	19.2% of income spent on GR taxable goods.
3.	Misc Other Sales Tax	$912,160	$1,938,822	$2,052,862	$2,026,614	$2,024,285	$2,084,677	$2,090,303	$2,188,471	6.9% of non salary on GR taxable goods.
4.	Avoided Tax Credits	$2,900,000	$17,013,832	$18,513,832	$21,971,082	$23,471,082	$24,971,082	$26,471,082	$27,971,082	Credits on insurance taxes for MHIP.
5.	Total	$15,599,740	$53,559,860	$57,288,553	$61,775,426	$62,967,197	$64,955,602	$67,167,055	$69,564,371	
E.	**GR Summary**									
1.	GR Cost New Eligibles	$0	$0	$0	($30,112,261)	($69,303,438)	($86,590,613)	($117,617,393)	($143,257,483)	
2.	GR Savings	$31,046,711	$71,355,159	$82,283,976	$81,243,754	$78,914,722	$79,579,907	$78,383,904	$77,975,810	
3.	New Revenues	$15,599,740	$53,559,860	$57,288,553	$61,775,426	$62,967,197	$64,955,602	$67,167,055	$69,564,371	
4.	Total	$46,646,450	$124,915,020	$139,572,528	$112,906,918	$72,578,481	$57,944,896	$27,933,566	$4,282,698	